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MANAGED CARE ENROLLED MEMBERS

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check Medicaid eligibility (Refer to Chapter 3) prior to rendering services and to confirm which MCO the individual is enrolled. The MCO may require a referral or prior authorization for the member to receive services. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations.

Even if the individual is enrolled with an MCO, some of the services may continue to be covered by Medicaid Fee-for-Service. Providers must follow the Fee-for-Service rules in these instances where services are "carved out" The MCO benefit plan. The carved-out services vary by managed care program. For example, where one program (Medallion 3.0) carves out Early Intervention, the CCC Plus program has this service as the responsibility of the MCO. Refer to each program's website for detailed information and the latest updates.

There are several different managed care programs (Medallion 3.0, CCC, CCC Plus, and PACE) for Medicaid individuals. DMAS has different MCOs participating in these programs. For providers to participate with one of the DMAS-contracted managed care organizations, they must be credentialed by the MCO and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

- Medallion 3.0:
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx

- Commonwealth Coordinated Care (CCC):
  http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx

- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx

- Program of All-Inclusive Care for the Elderly (PACE):
  http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

At this time, individuals enrolled in the three HCBS waivers that specifically serve individuals with intellectual and developmental disabilities (DD) (the Building Independence (BI) Waiver, the Community Living (CL) Waiver, and the Family and Individual Supports (FIS) Waiver)

will be enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services will continue to be covered through the Medicaid fee-for-service program with the Virginia Department of Behavioral Health & Developmental Services (DBHDS). Individuals enrolled in the Governor's Access Plan (GAP) will also continue to be covered through the Medicaid fee-for-service program.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, MCO enrollment, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: **www.virginiamedicaid.dmas.virginia.gov.** If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

PARTICIPATING PROVIDER

A participating provider is an agency, program, institution, facility, or person that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed contract and is successfully credentialed with the Behavioral Health Services Administrator (BHSA)) and/or a DMAS contracted managed care organization (MCO).

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid members. All Addiction and Recovery Treatment Services (ARTS) providers are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with the MCOs and the BHSA and state and federal regulations.

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)

The DMAS contracted MCOs and the BHSA work with DMAS to improve access to high quality ARTS services and improve the value of services purchased by the Commonwealth. The MCOs and the BHSA administer a comprehensive care coordination model which is expected to provide high quality care to Medicaid, FAMIS and GAP members and to reduce unnecessary and duplicative expenditures.

The MCOs and the BHSA are authorized to create, manage, enroll, and train a provider network; perform service authorizations; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered ARTS services.

DMAS, the MCOs and the BHSA authority, acting on behalf of DMAS, shall include entering into or terminating contracts with providers as described in any contract between a provider and DMAS or its contractors.

Responsibilities of the MCOs and the BHSA as they administer the ARTS benefit include the following:

- Comprehensive care coordination including coordination with Medicaid/FAMIS managed care plans providing coverage of acute care services;
- Promotion of evidence-based best practices and more efficient utilization of services;
- Development and monitoring of progress towards outcomes-based quality measures;
- Management of a centralized call center to provide eligibility, benefits, referral and appeal information with access to emergency services after hours;
- Provider recruitment, issue resolution, network management, and training;
- Service authorization;
- Member outreach, education and issue resolution;
- Claims processing and reimbursement for provision of ARTS services for enrolled members; and
- Promotion of a comprehensive Recovery-Oriented System of Care.

Noted below are two (2) concepts that should be reflected in all providers' service delivery practices and that support the principles noted above.

Recovery and Resiliency

DMAS encourages providers to provide high quality, consumer-focused, recovery-based behavioral health services for individuals enrolled in Virginia Medicaid, FAMIS and GAP. The ARTS provider network shall integrate these principles into their practices and service delivery operations. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Cultural and Linguistic Competencies

DMAS encourages providers to demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express mental and emotional distress, illness and conditions.

Development of cultural and linguistic competency means that providers have the ability to value diversity, adapt to diverse populations, obtain any needed education and training in order to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over extended periods of time as cultures change.

Providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS) should refer to DBHDS for guidance in this area.

PROVIDER ENROLLMENT

To be a network provider of ARTS with the DMAS contracted MCOs and BHSA, providers must be credentialed and enrolled according to all applicable MCO, BHSA and DMAS standards. Providers are subject to applicable Department of Health Professions, Virginia Department of Health (VDH), and DBHDS licensing requirements.

Additionally, any licensed practitioner joining a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with the MCOs and the BHSA prior to rendering services. To initiate the application process for the MCOs and the BHSA or for questions related to contracting and the credentialing process, providers should contact the specific MCOs and the BHSA.

All providers of the ARTS services listed below shall submit the appropriate ARTS Attestation Credentialing Packet to the MCOs and the BHSA to initiate the credentialing process. The ARTS Attestation Forms and Staff Roster are posted online at: http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx.

- **ARTS Attestation Form for ASAM Level 2.1 to 3.7**, ARTS Staff Roster and copy of relevant licenses are required for the following:
    - Substance Use Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7) (DBHDS license); and
    - Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5) (DBHDS license).

All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership. Providers are required to verify that they have the appropriate license for the service they are requesting based on the crosswalk of license type to ASAM level. The crosswalk can be found in Appendix A.

Healthcare providers are required to submit their National Provider Identifier (NPI) number on all claims and correspondence submitted to the MCOs, the BHSA and DMAS. Community

Service Boards (CSBs)/ Behavioral Health Authorities (BHAs) may use the organization NPI for purposes of billing. Provider NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to referring provider NPIs and prescribing provider NPIs.

This Medicaid provider manual contains instructions for billing and specific details concerning the Medicaid ARTS Program. Providers must comply with all sections of this manual, their contract and policies with the MCOs and the BHSA and related state and federal regulations to maintain continuous participation in the Medicaid Program.

Rate Setting Process for ARTS Residential Treatment Providers

All new Residential Treatment Facilities or providers adding on a new ASAM Level of Care for Residential Services (ASAM Level 3.3, 3.5 or 3.7) are required to file a pro-forma cost report for the determination of the initial rate. Allowable costs for reimbursement purposes are determined in accordance with Medicare Principles of Reimbursement, including the rules set forth in the Provider Reimbursement Manual, (CMS Pub 15-1). Allowable costs for determining the Residential Treatment Facility Rate do not include costs for drugs and professional (physician) services or primary/secondary/post-secondary education costs. The Residential Treatment Facility Rate cannot exceed $393.50 per day. Drugs and professional services must be billed directly to the MCO or the BHSA (professional services) / BHSA (pharmacy), depending on the member's benefit.

A copy of the pro-forma cost reporting form RTF-608 can be found on the Medicaid Web Provider Portal at https://www.virginiamedicaid.dmas.virginia.gov under "Provider Services" and "Provider Forms Search" section. Complete the RTF – 608 Cost Reporting Form in accordance with the following instructions and submit with additional documentation per Attachment A – Submission Instructions. The completed cost report with additional information as described in the instructions should be submitted to the DMAS cost settlement and auditing contractor.

PROVIDER SCREENING REQUIREMENTS

All providers must now undergo a federally mandated comprehensive screening before their application for participation or contract is approved by the MCOs, the BHSA or DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies

to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as "limited", "moderate" or "high". Please refer to the table in the Exhibits of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre- and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers who are enrolling with DMAS or the BHSA and meet the provider types indicated in the Appendix of this Chapter are required to pay an application fee set forth in Section 1866(j)(2)(C) of the Social Security Act and 42 CFR 455.460. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider

enrollment paper applications, online enrollment tool, and revalidation process. **The application fee requirements are also outlined in the Appendix section of this provider manual.** Providers shall refer to the specific MCOs for any additional requirements.

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied. An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

REVALIDATION REQUIREMENTS

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via the contracted MCO, the BHSA or DMAS.

Providers will receive written instructions from the MCOs, the BHSA or DMAS regarding the revalidation process, revalidation date and the provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, the MCOs, BHSA and DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members, the provider must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. ARTS providers approved for participation in the MCOs and BHSA provider network must perform the following activities as well as any others specified by DMAS:

- Immediately notify DMAS, the MCOs, and the BHSA in writing whenever there is a change in the information that the provider previously submitted. For a change of address, notify DMAS, the MCOs and the BHSA prior to the change and include the effective date of the change;

- Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS, the MCOs and the BHSA require, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

- Use the MCOs, BHSA and DMAS designated methods for submission of charges;

- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Assure the individual's freedom to reject medical care and treatment;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be

denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;

- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

- Charge the MCOs, BHSA and DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;

- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party;

- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency". The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge the MCOs, BHSA, DMAS or an individual for broken or missed appointments;

- Accept assignment of Medicare benefits for dual eligible Medicaid enrolled individuals;

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;

- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;

- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided;

- In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members; and

- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public.

- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

In order to comply with federal regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the person or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded person or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.

2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.

3. Immediately report to the contracted MCOs and the BHSA any exclusion information discovered. Such information should also be sent in writing and should include the person or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

   DMAS
   Attn: Program Integrity/Exclusions
   600 E. Broad St, Ste 1300
   Richmond, VA 23219
   -or-
   E-mailed to: providerexclusions@dmas.virginia.gov

SPECIFIC PROVIDER REQUIREMENTS

Addiction and Recovery Treatment Services

In addition to the following licensure requirements, substance use disorder treatment providers including outpatient physician and clinic services, intensive outpatient, partial hospitalization, residential treatment services and inpatient withdrawal management services (as defined in 12VAC30-130-5040 through 12VAC30-130-5150), must also be qualified by training and experience as defined in the American Society of Addiction Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related and Co-occurring Conditions, Third Edition, as published by the American Society of Addiction Medicine. The ASAM Criteria establishes standards for substance use/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities.

Direct Supervision of Residents and Supervisees

When plans of care and psychotherapy or counseling services are provided by one of the following: "Residents" under supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10) or licensed substance abuse treatment practitioner (18VAC115-60-10) approved by the Virginia Board of Counseling; "Residents in psychology" under supervision of a licensed clinical psychologist approved by the Virginia Board of Psychology (18VAC125-20-10); "Supervisees in social work" under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work

(18VAC140-20-10), to support the billing of these services, the licensed supervisor must ensure that:

- Therapy or counseling sessions rendered by a Resident or Supervisee must be provided under the direct, personal supervision of a qualified, Medicaid enrolled provider.

- The therapy session must contain at a minimum the dated signature of the Resident or Supervisee rendering the service but also include the dated signature of the qualified, Medicaid enrolled, licensed supervising provider.

- Each therapy session must contain the dated co-signature of the supervising provider within one business day from the date the service was rendered indicating that he or she has reviewed the note. The direct supervisor can be the licensed program supervisor/manager for the agency.

SPECIFIC ASAM LEVEL OF CARE STAFFING REQUIREMENTS

These ARTS services, as defined by ASAM and DMAS policy, include the following:

- Medically Managed Intensive Inpatient Services (ASAM Level 4);

- Substance Use Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7);

- Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5);

- Opioid Treatment Services ((Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT))*;

- Substance Use Outpatient Services (ASAM Level 1);

- Early Intervention Services / Screening Brief Intervention and Referral to Treatment (SBIRT) (ASAM 0.5);

- Substance Use Care Coordination;

- Substance Use Case Management Services, and

- Withdrawal Management services shall be provided when medically necessary, as a component of the following:

    - Medically Managed Inpatient Services (ASAM Level 4);

    - Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7);

- Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5);
- Opioid Treatment Services (Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT)*; and
- Substance Use Outpatient Services (ASAM Level 1).

*Opioid Treatment Services are defined in the Opioid Treatment Services Supplement to this manual.

Medically Managed Intensive Inpatient Services (ASAM Level 4.0) (H0011/rev.1002)

Medically managed intensive inpatient services (ASAM Level 4.0) are provided in medical beds in acute care general hospitals licensed by the Virginia Department of Health as meeting the conditions for participation under Title XVIII of Public Law 89-97 and are limited to an age group not eligible for Title XVIII benefits. These facilities are accredited by the Joint Commission on Accreditation for Hospitals and have a Utilization Review Plan that meets the Title XVIII and Title XIX standards for utilization review. ASAM Level 4.0 providers shall be the designated setting for medically managed intensive inpatient treatment and shall be contracted by the MCOs and the BHSA.

ASAM Level 4.0 providers shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and/or other drugs.

Medically managed intensive inpatient services (ASAM Level 4.0) shall meet these staff requirements:

1. An interdisciplinary staff of appropriately credentialed clinical staff including, for example, addiction-credentialed physicians or physicians with experience in addiction medicine, licensed nurse practitioners, licensed physician assistants, registered nurses, licensed professional counselors, licensed clinical psychologists, or licensed clinical social workers shall assess and treat individuals with severe substance use disorders or addicted individuals with concomitant acute biomedical, emotional, or mental health disorders.

2. Medical management by physicians and primary nursing care shall be available 24 hours per day and counseling services shall be available 16 hours per day.

Co-Occurring Enhanced Programs

Medically managed intensive inpatient services (ASAM Level 4.0) co-occurring enhanced programs shall meet these staff requirements:

1. Credentialed Addiction Treatment Professionals who assess and treat the individual's co-occurring mental illness shall be knowledgeable about the biological and psychosocial dimensions of psychiatric disorders and their treatment.

2. Co-occurring programs shall be led by an Addiction-Credentialed Physician.

Medically Monitored Intensive Inpatient Services (Adult) and Medically Monitored High Intensity Inpatient Services (Adolescent) (ASAM Level 3.7) (H2036/rev 1002)

ASAM Level 3.7 programs provide a planned and structured regimen of 24 hours per day physician directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient/residential treatment center setting. They function under a defined set of policies, procedures, and clinical protocols.

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) services may be offered in freestanding, appropriately licensed facility located in a community setting, or a specialty unit in a licensed health care facility such as general or psychiatric hospital. ASAM Level 3.7 providers are providers contracted by the MCOs and the BHSA. Providers shall be licensed by DBHDS as one of the following license types:

- Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;
- Substance Abuse Residential Treatment Services (RTS) for adults/children with a DBHDS Managed Withdrawal License;
- Residential Crisis Stabilization Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;
- Substance Abuse Residential Treatment Services (RTS) for Women with Children with a DBHDS Managed Withdrawal License;
- Psychiatric Residential Treatment Facility for children with a substance abuse residential license and a DBHDS Managed Withdrawal License;
- Managed Withdrawal-Medical Detox Adult Residential Treatment Service (RTS) License; or
- Medical Detox/Chemical Dependency Unit for Adults.

ASAM Level 3.7 providers shall meet these staff requirements:

1. The interdisciplinary team shall include credentialed addiction treatment professionals acting within the scope of their practice and addiction-credentialed physicians or physicians with

experience in addiction medicine to assess and diagnose, treat, and obtain and interpret information regarding the individual's psychiatric and substance use disorders.

2. Clinical staff shall be knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental illnesses and their treatment. Clinical staff shall be able to identify and diagnose acute psychiatric conditions, symptom increase or escalation, and decompensation. Clinical staff shall have specialized training in behavior management techniques and evidenced based best practices in working with individuals experiencing addiction.

3. Behavior management is used here as a generic phrase that includes a variety of behavioral intervention techniques that are intended to bring about positive behavioral changes. Behavioral management is a proactive approach to reducing disruptive and/or harmful behaviors. This includes but is not limited to: cognitive-behavioral therapy, contingency contracting, contingency management, token economy, motivational enhancement therapy, crisis prevention, and other techniques. The clinical staff personnel records should reflect having received training in behavior management techniques.

4. Clinical staff shall be able to provide a planned regimen of 24 hours per day professionally directed evaluation, care and treatment including the administration of prescribed medications.

5. An addiction-credentialed physician or physician with experience in addiction medicine shall oversee the treatment process and assure the quality of care. Licensed physicians or physician extenders under supervision of a physician shall perform physical examinations for all individuals who are admitted within 24 hours of admission, except for instances when ASAM Level 3.7 is a step-down from ASAM Level 4.0 within the same facility, in which case records from the physical exam within the preceding 7 days should be evaluated by a physician within 24 hours of admission. The physician or psychiatrist, or physician extender as defined in 12VAC30-130-5020, if knowledgeable about addiction treatment, shall have the ability to supervise addiction pharmacotherapy, integrated with psychosocial therapies in addiction treatment.

Co-Occurring Enhanced Programs

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) co-occurring enhanced programs as required by ASAM shall meet staff requirements as follows:

1. Psychiatrists and credentialed addiction treatment professionals who have specialized training in behavior management techniques as defined earlier in this chapter, and evidenced-

based practices related to addiction and co-occurring conditions shall be available to assess and treat co-occurring psychiatric disorders.

2. Access to an addiction-credentialed physician shall be available 24 hours per day along with access to either a psychiatrist, a certified addiction psychiatrist, or a psychiatrist with experience in addiction medicine.

3. Credentialed addiction treatment professionals shall have experience and training in addiction and mental health to understand the signs and symptoms of mental illness and be able to provide education to the individual on the interaction of substance use and psychotropic medications.

4. Registered nurses and licensed practical nurses shall be available to provide care to and observation of individuals as defined in the individual service plan.

Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium-Intensity Residential Services (Adolescent) (ASAM Level 3.5) (H0010/rev 1002)

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) are residential treatment service providers who are contracted by the MCOs, and the BHSA. Providers shall be licensed by DBHDS as a provider of one of the following:

- Substance Abuse Residential Treatment Services (RTS) for Adults or Children;
- Psychiatric Unit that have substance abuse on their license or within the "licensed as statements";
- Substance Abuse RTS for Women with Children;
- Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the "licensed as statements."; or
- Psychiatric Residential Treatment Facility for Children that have substance abuse on their license or within the "licensed as statements".

If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.

Residential treatment providers (ASAM Level 3.5) shall meet these staff requirements:

1. The interdisciplinary team shall include credentialed addiction treatment professionals acting within the scope of their practice, physicians, or physician extenders and allied health professionals.

2. Staff shall provide 24 hours per day awake supervision on site. In addition to this requirement, the provider's staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-590 and 12VAC35-46-870.

3. Clinical staff shall be experienced in and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders and be able to identify and diagnose acute psychiatric conditions and decompensation. Clinical staff shall have specialized training in relevant behavior management techniques and evidence-based best practices in working with individuals experiencing addiction.

4. Substance use case management shall be provided in this level of care to coordinate all services offered to each member. Note: Substance use case management services (H0006) are not reimbursable for individuals while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.

5. Behavior management is used here as a generic phrase that includes a variety of behavioral intervention techniques that are intended to bring about positive behavioral changes. Behavioral management is a proactive approach to reducing disruptive and/or harmful behaviors. This includes but is not limited to: cognitive-behavior therapy, contingency contracting, contingency management, token economy, motivational enhancement therapy, crisis prevention, and other techniques. The clinical staff personnel records should reflect having received training in behavior management techniques.

6. Staff who are credentialed as addiction treatment professionals, physicians, or physician extenders shall be available on-site or by telephone 24 hours per day, seven days per week to respond to member treatment needs, assess and treat co-occurring biological and physiological disorders and to monitor the individual's administration of medications in accordance with a physician's prescription.

Co-Occurring Enhanced Programs

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) co-occurring enhanced programs as required by ASAM shall have staff requirements as follows:

1. Staff shall be credentialed addiction treatment professionals who are able to assess and treat co-occurring substance use and psychiatric disorders.

2. Credentialed addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental illness, and be able to provide education to the individual on the interactions with substance use and psychotropic

medications. Credentialed addiction treatment professional staff shall be available on site or by telephone 24 hours per day and 7 days per week.

3. Staff shall provide 24 hours per day awake supervision on site. The provider's staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-590 and 12VAC35-46-870.
4. Registered nurses and licensed practical nurses shall be available to provide care and observation to individuals as defined in the individual service plan.

Clinically Managed Population-Specific High Intensity Residential Service (ASAM Level 3.3) (H0010/rev 1002)

Clinically managed population-specific high intensity residential services (ASAM Level 3.3) are facility-based providers and who are contracted with the MCOs, MMPs and the BHSA. Providers shall be licensed by DBHDS as one of the following:

- Substance Abuse Residential Treatment Services (RTS) for Adults;
- Substance Abuse Residential Treatment Services (RTS) for Women with Children;
- Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the "licensed as statements."; or
- Psychiatric Residential Treatment Facility for Children that have substance abuse on their license or within the "licensed as statements."

If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detoxification license.

Residential treatment service providers for clinically managed population-specific high intensity residential services (ASAM Level 3.3) shall meet these staff requirements:

1. The interdisciplinary team shall include credentialed addiction treatment professionals acting within the scope of their practice, physicians, or physician extenders and allied health professionals in an interdisciplinary team.

2. Staff shall provide 24 hours per day awake supervision on site. The provider's staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-590 and 12VAC35-46-870.

3. Clinical staff shall be experienced and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders and be available on-site or by telephone 24 hours per day. Clinical staff shall be able to identify and diagnose acute psychiatric conditions and decompensation.

4. Substance use case management is included in this level of care to coordinate all services offered to each member. Note: Substance use case management services (H0006) are not reimbursable for individuals while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.
5. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and to monitor the individual's administration of prescribed medications.

Co-Occurring Enhanced Programs

Clinically managed population-specific high intensity residential service co-occurring enhanced programs, as required by ASAM, shall have staff requirements as follows:

1. Staff shall be credentialed addiction treatment professionals who are able to assess and treat co-occurring substance use and psychiatric disorders.
2. Credentialed addiction treatment professionals shall be available to assess and treat co-occurring substance use and mental health disorders using specialized training in behavior management.
3. Clinical staff shall be knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental illnesses and their treatment. Clinical staff shall be able to identify and diagnose acute psychiatric conditions, symptom increase or escalation, and decompensation. Clinical staff shall have specialized training in relevant behavior management techniques and evidenced based best practices in working with individuals experiencing addiction.
4. Behavior management is used here as a generic phrase that includes a variety of behavioral intervention techniques that are intending to bring about positive behavioral changes. Behavioral management is a proactive approach to reducing disruptive and/or harmful behaviors. This includes but is not limited to: cognitive-behavior therapy, contingency contracting, contingency management, token economy, motivational enhancement therapy, crisis prevention, and other techniques. The clinical staff personnel records should reflect having received training in behavior management techniques.
5. Registered nurses and licensed practical nurses shall be available to provide care and observation to individuals as defined in the individual service plan.

Clinically Managed Low Intensity Residential Services (ASAM Level 3.1) (H2034)

Clinically Managed Low Intensity Residential Services (ASAM Level 3.1) shall be contracted with the MCOs and BHSA. The provider shall be licensed by DBHDS as a provider of one of the following:

- Mental Health & Substance Abuse Group Home Service for Adults or Children; or
- Supervised Residential Treatment Services for Adults.

Note: DBHDS is no longer issuing the Substance Abuse Halfway House for Adults licenses. Providers who need to update their licenses should contact their licensing specialist with DBHDS for further guidance.

Clinically directed program activities constituting at least five hours per week of professionally directed treatment shall be designed to stabilize and maintain substance use disorder symptoms and to develop and apply recovery skills. ASAM Level 3.1 clinically managed low intensity residential service providers shall meet these staff requirements:

1. Staff shall provide 24 hours per day awake supervision on site. In addition to this requirement, the provider's staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-590 and 12VAC35-46-870.
2. Clinical staff shall be experienced and knowledgeable about the biopsychosocial and psychosocial dimensions and treatment of substance use disorders and able to identify the signs and symptoms of acute psychiatric conditions and decompensation.
3. An addiction-credentialed physician, physician with experience in addiction medicine, or physician extenders under supervision of a physician shall review the residential group home admission to confirm medical necessity for services, and a team of credentialed addiction treatment professionals shall develop and shall ensure delivery of the individual service plan.
4. Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving ASAM Level 3.1 services in a group home setting.
5. Coordination with the member's primary care physician and other specialists shall occur as needed to review treatment and help align treatment plans among all treating practitioners.
6. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and appropriately trained staff to monitor the individual's administration of prescribed medications.

Co-Occurring Enhanced Programs

Clinically managed low intensity residential services (ASAM Level 3.1) co-occurring enhanced programs as required by ASAM shall have staff requirements as follows:

1. Credentialed addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental illness and to understand and be able to explain to the individual the purpose of psychotropic medications and interactions with substance use.
2. Access to an addiction credentialed physician shall be available for consultation as necessary.
3. Registered nurses and licensed practical nurses shall be available to provide care and observation to individuals as defined in the individual service plan.

Partial Hospitalization Services (ASAM Level 2.5) (S0201/rev 0913)

Partial Hospitalization Services (ASAM Level 2.5) shall be a structured program of skilled treatment services for adults, children and adolescents delivering a minimum of 20 hours per week and at least five service hours per service day of skilled treatment services with a planned format including individual and group counseling, medication management, family therapy, education groups, occupational and recreational therapy and other therapies. Withdrawal management services may be provided as necessary. Time not spent in skilled, clinically intensive treatment is not billable.

Partial hospitalization services (ASAM Level 2.5) providers shall be licensed by DBHDS as a provider of Substance Abuse Partial Hospitalization Program or Substance Abuse/Mental Health Partial Hospitalization Program and contracted with the MCOs and the BHSA. Partial hospitalization service providers shall meet the ASAM Level 2.5 support systems and staff requirements as follows:

1. An interdisciplinary team comprised of credentialed addiction treatment professionals acting within the scope of their practice and an addiction-credentialed physician, or physician with experience in addiction medicine, or physician extenders as defined in 12VAC30-130-5020, shall be required.
2. Physicians shall have specialty training or experience, or both, in addiction medicine or addiction psychiatry. Physicians who treat adolescents shall have experience with adolescent medicine.
3. Program staff shall be cross-trained to understand signs and symptoms of mental illness and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.

4. Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving partial hospitalization services. GAP members may only receive GAP case management.

Partial hospitalization services (ASAM Level 2.5) co-occurring enhanced programs shall have staff requirements as follows:

1. Credentialed addiction treatment professionals shall have experience assessing and treating co-occurring mental illness.
2. Clinical leadership and oversight shall be provided by an addiction credentialed physician or physician with experience in addiction medicine, or physician extender as defined in 12VAC30-130-5020.
3. Co-occurring programs shall provide case management for individuals with co-occurring mental illness who have unstable living environments or lack positive support systems conducive to recovery. Staff providing case management shall have training and experience working with individuals with a dual diagnosis in substance use and mental health disorders. Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving partial hospitalization services.

Intensive Outpatient Services (ASAM Level 2.1) (H0015/rev 0906)

Intensive outpatient services (ASAM Level 2.1) shall be a structured program of skilled treatment services for adults, children and adolescents delivering a minimum of 3 service hours per service day to achieve 9 to 19 hours of services per week for adults and 6 to 19 hours of services per week for children and adolescents.

Intensive outpatient services (ASAM Level 2.1) shall be provided by providers/programs licensed by DBHDS as a provider of Substance Abuse Intensive Outpatient Service for Adults, Children, and/or Adolescents and contracted with the MCOs and the BHSA to provide this service. Intensive outpatient service providers shall meet the ASAM Level 2.1 staff requirements as follows:

1. An interdisciplinary team of credentialed addiction treatment professionals acting within the scope of their practice is required.
2. Generalist physicians or physicians with experience in addiction medicine are permitted to provide general medical evaluations and concurrent/integrated general medical care.
3. Staff shall be cross-trained to understand signs and symptoms of psychiatric disorders and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.
4. Emergency services, which shall be available, when necessary, by telephone 24 hours per day and seven days per week when the treatment program is not in session.

5. Direct affiliation with (or close coordination through referrals to) higher and lower levels of care and supportive housing services such as Clinically Managed Low Intensity Residential Services.

Co-Occurring Enhanced Programs

Intensive outpatient services (ASAM Level 2.1) co-occurring enhanced programs shall have staff requirements as follows:

1. Credentialed addiction treatment professionals shall have experience assessing and treating co-occurring mental illness.
2. Clinical leadership and oversight, at a minimum, have capacity to consult with an addiction credentialed physician, or a physician with experience in addiction medicine, or a physician extender as defined in 12VAC30-130-5020

Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving intensive outpatient services. GAP members may only receive GAP case management.

Preferred Medication Assisted Treatment Providers

Residential treatment (ASAM Level 3.1, 3.3, 3.5 and 3.7), Intensive Outpatient (ASAM Level 2.1) and Partial Hospitalization (ASAM Level 2.5) providers, who are providing Medication Assisted Treatment (MAT) and who are currently credentialed with the MCO or the BHSA as an ARTS provider can apply to be a "**Preferred Medication Assisted Treatment Provider**". The Preferred MAT status will allow the buprenorphine waivered practitioner of the facility to prescribe buprenorphine related products to be filled at local pharmacy and be waived from having to complete the service authorization process. The Preferred Medication Assisted Treatment attestation packet is located online at: http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx.

Providers should complete these forms and send to DMAS at fax: 804-452-5450 for the physician team to review for decision. If DMAS approves the application, DMAS will notify the MCOs and the BHSA. Providers will still need to complete the credentialing process with each MCO and the BHSA to ensure that the buprenorphine waivered practitioners are credentialed to be reimbursed for the professional services and waive the buprenorphine service authorization.

Outpatient Substance Use Disorder Treatment Services (ASAM Level 1.0)

Outpatient substance use disorder treatment services shall be provided by a credentialed addiction treatment professional, psychiatrist, or physician, under the scope of their practice, contracted by the MCOs or the BHSA to perform these services in the following community based settings including but not limited to: primary care clinics, outpatient health system clinics,

psychiatry clinics, FQHCs, Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs), local health departments, and provider offices - private or group practices.

The ARTS specific procedure codes and reimbursement structure for outpatient services are posted online at: http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx .

Outpatient services (ASAM Level 1) staff requirements include:

1. A credentialed addiction treatment professional; or

2. A registered nurse or a practical nurse who is licensed by the Commonwealth (18VAC90-2010 et seq.) with at least one year of clinical experience involving medication management.

Outpatient services (ASAM Level 1) co-occurring enhanced programs shall include:

1. Ongoing substance use case management for highly crisis prone individuals with co-occurring disorders. Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving outpatient services. GAP members may only receive GAP case management.

2. Credentialed addiction treatment professionals who are trained in severe and chronic mental health and psychiatric disorders and are able to assess, monitor and manage individuals who have a co-occurring mental health disorder.

Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5) (99408 and 99409)

Early intervention (ASAM Level 0.5) settings for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services shall include health care settings such as: local health departments, FQHCs, rural health clinics (RHCs), Community Services Boards (CSBs)/Behavioral Health Authorities (BHAs), health systems, emergency departments of hospitals, pharmacies, physician offices and private and group outpatient practices. Individual practitioners shall be licensed by DHP and either directly contracted by the MCOs and the BHSA to perform this level of care, or employed by organizations that are contracted by the MCOs and the BHSA.

Provider qualifications of SBIRT (ASAM Level 0.5) include: Physicians, pharmacists, and other credentialed addiction treatment professionals, within the scope of their practice, shall administer the evidence-based screening tool with the individual and provide the counseling and intervention. Licensed providers may delegate administration of the evidence-based screening tool, counseling and intervention to other clinical staff as allowed by their scope of practice, such as physicians delegating to a licensed registered nurse or licensed practical nurse. Billing of

SBIRT must be through the licensed agency or provider who is credentialed with the MCO or BHSA.

Substance Use Case Management (H0006)

Substance Use Case Management services are for individuals who have a primary diagnosis of substance use disorder. Provider qualifications for a substance use case management shall meet the following criteria:

1. The enrolled provider must have the administrative and financial management capacity to meet state and federal requirements;

2. The enrolled provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

3. The enrolled provider must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of substance abuse case management services.

4. Substance use case management services shall be provided by a professional or professionals who meet at least one of the following criteria:

    a. At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least either 1) one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or 2) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or

    b. Licensure by the Commonwealth as a registered nurse with at least either: 1) one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder; or 2) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or

    c. Board of Counseling Certified Substance Abuse Counselor (CSAC) or CSAC-Assistant under supervision as defined in 18VAC115-30-10 et seq. Community Service Boards that have CSACs or CSAC–Assistants performing Substance Use Case Management Services shall be under supervision according to the supervision requirements of the Board of Counseling which allows for supervision by another person with substantially equivalent education, training, and experience, or such counselor shall be in compliance with the supervision requirements of a licensed facility, as long as the they are in compliance with the supervision requirements of the licensed facility (§54.1-3507.1 and §54.1-3507.2).

5. GAP members are not eligible to receive substance use case management but may receive GAP case management services which covers GAP member case management for both Substance Use and Mental Health.

Peer Support Services

The Recovery Resiliency and Wellness Plan is required by providers offering peer support services to members. The comprehensive document shall be individualized and developed within 30 days of the initiation of services. The Recovery Resiliency and Wellness Plan shall be maintained in the member's medical record.

For more detail about the requirements for the Recovery Resiliency and Wellness Plan please see the Peers Services Manual Supplement.

FREEDOM OF CHOICE

The member shall have freedom of choice in the selection of a provider of services. Generally, however, payments are limited under the Medical Assistance Program to providers who are qualified to participate in the Program under Title XVIII and who have signed a written agreement with DMAS and are contracted and credentialed with the Medicaid MCOs and BHSA as required.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provision for disabled individuals in his or her program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical assistance shall be reduced to the extent that they are available through other federal, state, or local programs, other insurance, or third party liability.

Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered individual. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare) -** Virginia Medicaid will pay the amount of any deductible or co-insurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible individuals covered by Medicare and Medicaid.

- **Workers' Compensation -** No Medicaid Program payments shall be made for an individual covered by Workers' Compensation.

- **Other Health Insurance -** When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries -** DMAS will seek repayment from any settlements or judgments in favor of Medicaid enrolled individuals who receive medical care as the result of the negligence of another. If an individual is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

- If there is an accident in which there is a possibility of third-party liability or if the individual reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 form to:

  Third Party Liability Unit
  Department of Medical Assistance Services
  600 East Broad Street, Suite 1300
  Richmond, Virginia 23219

ASSIGNMENT OF BENEFITS

If a Virginia Medical Assistance Program beneficiary is the holder of an insurance policy which assigns benefits directly to the patient, **the hospital must require that benefits be assigned to the hospital or refuse the request for the itemized bill** that is necessary for the collection of the benefits.

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

For Medicaid purposes, a required physician signature may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS and review Chapter IVI in this manual for information on medical record documentation and retention for psychiatric and substance use disorder services.

All physician services provided shall be documented in the medical record at the time they are rendered, whether in person or via telehealth. All patient medical records, whether paper-based or electronic, shall be signed with the first initial, and last name and title and dated (month, day, and year) no later than 14 calendar days from the date of service delivery. The 14-day signature requirement shall apply in all cases, except where a federal or state signature deadline requires a time frame different than 14 days.

REVIEW AND EVALUATION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients. This function is handled by the Virginia Medical Assistance Program's Prepayment and Post payment Review Sections.

Provider and recipient utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. To ensure a thorough and fair review, trained professionals review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, DMAS, the MCOs or the BHSA may limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by personnel with detailed instructions. This will also apply when information is requested about a recipient or when a recipient is

restricted to the physician or pharmacy, or both, of his or her choice because of misutilization of Medicaid services.

Additional information on utilization review activities may be found in Chapter VI, Utilization Review and Control.

FRAUD

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or items of value for services rendered or supposedly rendered to individuals enrolled in Medicaid. A provider participation agreement will be terminated or denied when a provider is found guilty of fraud.

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either Federal or State Court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, United States Attorney General, or the appropriate law enforcement agency.

Further information about fraudulent claims is available in Chapter VI, "Utilization Review and Control" of this manual.

TERMINATION OF PROVIDER PARTICIPATION

DMAS, the MCOs or the BHSA may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS, the MCOs or the BHSA for services provided to customers subsequent to the date specified in the termination notice.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the contracted MCO, BHSA, the DMAS Director and Conduent – Provider Enrollment Services (PES) 30 days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Virginia Medicaid - PES
PO Box 26803
Richmond, Virginia 23261-6803

Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325 (D) and (E). The provider may appeal the decision in accordance with the Administrative Process Act (APA) (Virginia Code §2.2-4000 et seq.), the State Plan for Medical Assistance provided for in § 32.1-325 et seq. of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial. This only applies to provider contracts with DMAS for fee-for-service or the BHSA. Providers denied or terminated from a MCO network do not have appeal rights with DMAS.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Section 32.1-325 (D) 2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS, the MCOs or the BHSA of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

PROVIDER RECONSIDERATION OF ADVERSE ACTIONS

Service providers seeking to contest an adverse action issued by the MCO or BHSA must follow the MCO's or BHSA's policies and procedures for requesting reconsideration. For information regarding the reconsideration process, providers should consult their agreement with the MCOs or the BHSA. The provider's exhaustion of the BHSA's reconsideration process is a mandatory pre-requisite to filing an appeal with DMAS.

PROVIDER APPEALS OF ADVERSE ACTIONS

Non-State Operated Provider

After exhausting the MCO's or the BHSA's reconsideration process, Medicaid-enrolled providers have the right to appeal adverse decisions to DMAS. Adverse actions that stem from DMAS may be appealed directly to DMAS.

A provider may appeal an adverse decision where a service has already been provided by filing a written notice for a first-level Informal Appeal with the DMAS Appeals Division **within 30 calendar days** of the receipt of the MCO's or the BHSA's final reconsideration decision or **within 30 calendar days** of receiving a notice of adverse action sent by DMAS. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

If the provider is dissatisfied with the first-level Informal Appeal decision, the provider may file a written notice for a second-level Formal Appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia,* § 2.2-4000 et seq. The notice for a second-level Formal Appeal must be filed **within 30 calendar days** of receipt of the first-level Informal Appeal decision. The notice for second-level Formal Appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

Administrative appeals of adverse actions concerning enrollment or provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA), the State Plan for Medical Assistance provided for in § 32.1-325 et seq. of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Court review of final agency determinations concerning enrollment or provider reimbursement shall be made in accordance with the APA.

If the provider is dissatisfied with the second-level Formal Appeal decision, the provider may file an appeal with the appropriate circuit court, in accordance with the APA and the Rules of Court.

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be deemed untimely.

The provider may not bill the individual (client) for covered services that have been provided and subsequently denied by the MCO, BHSA or DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS or its Contractors. When lump sum cash payment is not made, interest shall be added

on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS or its Contractors, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS, MCOs or the BHSA takes an adverse action. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration or re-review of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process for state-operated providers will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 days of receipt of the decision, or within 15 days of receipt of the notice of termination or denial of enrollment of their DMAS agreement pursuant to §32.1-325(D) of the Code of Virginia, or within 90 days of receipt of the Notice of Program Reimbursement of a cost report. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee reviews the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the

Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

CLIENT APPEALS

For client appeals information, see Chapter III of the Provider Manual.

EXHIBITS

Provider Risk Category Table Page 1 of 2

Application	Rule Risk Category	App Fee Requirement Yes(Y) or No(N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate –Revalidating	Y
	High – Newly enrolling	
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate –Revalidating	Y

	High – Newly enrolling	
Home Health Agency - Private Owned	Moderate –Revalidating	Y
	High – Newly enrolling	
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate –Revalidating	Y
	High – Newly enrolling	
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N

Appendix A

ASAM Level of Care Crosswalk with DBHDS Licenses/Numbers			
ASAM Level of Care	**ASAM Description**	**DBHDS Licenses**	**DBHDS License Numbers**
4.0	Medically Managed Intensive Inpatient	n/a - VDH license only	n/a
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;	04-001 thru 004 (adults) 04-005 (children) 04-011 thru 012 (medical detox) or 01-025 thru 026 (managed withdrawal)
		Substance Abuse Residential Treatment Services (RTS) for adults/children with a DBHDS Managed Withdrawal License;	01-006 (adults) 14-007(children) 01-025 thru 026 (managed withdrawal)
		Residential Crisis Stabilization Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;	01-019 (adults) 01-020 (children) 04-011 thru 012 (medical detox) or 01-025 thru 026 (managed withdrawal)
		Substance Abuse Residential Treatment Services (RTS) for Women with Children with a DBHDS Managed Withdrawal License;	01-033 thru 034 (Women) 01-025 thru 026 (managed withdrawal)
		Level C or Mental Health Residential Children with a substance abuse residential license and a DBHDS Managed Withdrawal License;	14-001 thru 003 w/ SA in licensed as description or 14-004 thru 006 14-054 thru 058 w/SA in licensed as description 01-025 thru 026 (managed withdrawal)
		Managed Withdrawal-Medical Detox Adult Residential Treatment Service (RTS) License; or	01-025 thru 026
		Medical Detox/Chemical Dependency Unit for Adults.	04-011 thru 012 (medical detox)
3.5	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)	Substance Abuse Residential Treatment Services (RTS) for Adults or Children;	01-006 (Adults) 14-007 (Child)
		Psychiatric Unit that have substance abuse on their license or within the "licensed as statements";	04-001 thru 004 (adults) 04-005 (children)
		Substance Abuse RTS for Women with Children;	01-033 thru 034 (Women)

		Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the "licensed as statements."; or	01-006 (Adults)
		Level C or Mental Health Residential Children that have substance abuse on their license or within the "licensed as statements".	14-001 thru 006 (only with SA in license description) 014-007 (only with SA in license description)
		If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.	04-011 thru 012 (medical detox) or 01-025 thru 026 (managed withdrawal)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	Substance Abuse Residential Treatment Services (RTS) for Adults;	01-006
		Substance Abuse Residential Treatment Services (RTS) for Women with Children;	01-033 thru 034 (Women)
		Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the "licensed as statements." or	01-006
		Level C or Mental Health Residential Children that have substance abuse on their license or within the "licensed as statements."	14-001 thru 006 (only with SA in license description) 14-007 (only with SA in license description)
		If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.	04-011 (medical detox – adults)
3.1	Clinically Managed Low-Intensity Residential Services	Mental Health & Substance Abuse Group Home Service for Adults or Children; or	01-003 (Adults) (only with SA in license description 14-033 (Children) 14-034 (Children
		Supervised Living Services for Adults.	01-013
		Note: DBHDS is no longer issuing the Substance Abuse Halfway House for Adults licenses. Providers who need to update their licenses should contact their licensing specialist with DBHDS for further guidance.	

2.5	Partial Hospitalization Services	Substance Abuse Partial Hospitalization program; or	02-021 (Adults)
		Substance Abuse/Mental Health Partial Hospitalization program	02-023 (Adolescents) (only with SA in license description)
2.1	Intensive Outpatient Services	Substance Abuse Intensive Outpatient Service for Adults, Children, and/or Adolescents	02-001 thru 002(Adults) 02-003 (Adolescents)
1.0	Outpatient Services	n/a - Individuals licensed by DHP DBHDS Outpatient License	n/a 07-004 thru 005 07-011
OTS	Opioid Treatment Program (OTP)	Medication Assisted Treatment/Opioid Treatment Services	06-001 thru 002
OTS	Office-Based Opioid Treatment (OBOT)	n/a – DMAS review	n/a
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)	n/a - Individuals licensed by DHP	n/a
n/a	Substance Use Case Management	Substance abuse case management services	16-003 16-001 (with SA listed)